CLIENT INFORMATION FORM (A)

Name: _________________________ **Subscriber ID #:**_________________**Group ID #:**__________

Address:____City____________________Zip______

Date of birth: ___/___/___ **Phone** - Daytime: __________________ Evening: ___________________

Employer: _______________________________ **Soc. Sec. # (if different from ID**#)__________________

Married: __ Single: _ Divorced: __ Widowed: __ Partner: ____

Emergency contact: _______________________ Relationship: _______________ Phone: __________

Please list any medical conditions for which you have been or presently are being treated:_________

____

Please list all prescription medication(s) you are taking & dosage:______________________________

____

Primary Care Physician: _______________________________________ Phone: __________________

Alcohol (current amount and frequency of use):____

Recreational drugs (which kind, current amount and frequency of use): ____________________________

Cigarettes: Current use: None ___ Amount smoked daily ______________

Previous psychotherapy: None ___ Yes ___When and with whom:________________________________

____

Previous psychiatric hospitalization(s): None ___ Yes ___ When and where:_____________________

Previous psychiatric medications: None ___ Yes ___ Which one(s) and when: ____________________

____

Reason for seeking treatment at this time:____

_______________________________________ ____________________________

Signature